Central MRS Meeting Notes
February 27, 2008
Forsyth County Library

Counties Present: Alamance, Davidson, Forsyth, Guilford, Mecklenburg, Moore, Randolph, Rockingham, Rowan, Stokes, Surry, Union, Wake, Yadkin.

Introductions
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Announcements

- Dear County Director Letter as a follow up to Foster Care data entered in the MRS database. Initially we said we would submit the last quarter of the fiscal year and the day before the data was due ACF decided that was not sufficient. We need data for selected sample case for the entire fiscal year. The letter references the previous communications regarding entering these visits, and then details which cases you need to enter for. This averages out to about 2 or 3 cases per county. Data should be submitted by close of business on Friday March 7th.
- Dear County Director Letter Regarding the new training requirements around training and CFT facilitation. This came out of a workgroup stemming from the PIP. The feedback from Feds was that CFTs worked great when they were done according to policy, but not as useful when they were not. County partners suggested that CFT training become mandated since CFTs have become such a central part of the way we work with families. This is the Step By Step training (2 day training). If you previously had Caution Family Meeting Ahead and Anchors Away you are ok, this new training combines those 2. If you are hired after 2/8/08 you have one year after your start date to complete the training, if you were already employed prior to that time, you have one year to complete it. This also removes the requirement for Effects of Separation and Loss.
    - There is also a required Facilitator training for anyone who is going to facilitate high or intensive risk meetings. This includes people outside the agency that you may contract with.
- Dear County Letter addressing the role of assessments in Juvenile Justice and Delinquency Centers. This is just a clarification letter.
- Heather referenced an Admin Letter that came out last week that allows counties to designate users to have a Supervisor role within the MRS database. This will allow these persons to edit closed records for their counties instead of having to call Heather.
- Dukes Evaluation - Nicole talked about next year and moving into new phases of the evaluation. The template for the fact sheets she used last year are on the web. All 100 counties will receive the fact sheet this year and it looks at different measures. It is critical that the 5104 and 5106 be completed, because much of the information from the fact sheet comes from these. (See last months notes for more complete

discussion of the fact sheets and where the data comes from.) Currently Duke is working on family phone interviews and CFT surveys.
- Very soon a call for Proposals will be coming out for the MRS Institute.

Using the CME program–
Laura Elmore from the Policy team talked about CMEs. This policy was recently revised. Wanted to discuss when was an appropriate situation to use these funds to ensure that they would be available when needed.

Child Medical Exams
- What kinds of cases are being referred? Obviously meth lab children, but what else?
    - One county refers all sex abuse with disclosure from the child (almost any kind of disclosure unless it is blatantly obvious that it is not true, not just penetration but fondling as well.)
- Counties are often choosing to have a Child Advocate do the interview as a part of a CME rather than having the DSS staff do it.
- Note*: The CME program is to be used when you cannot otherwise make a decision Not to confirm what you already know*. – if the parents admit that they made the bruises, and you just want to use the CME to determine if they were made by a belt, as the parents claim, or if it was a board.
    - You can use the providers and get supporting information but it is not with CME funding. If they have Medicaid that would be used to pay for it. If they don't then you will have to find other funding.
    - If you use this funding for cases to back up a decision that you have already made then it is possible that the funding will be exhausted and then it will not be available later in the fiscal year for those cases where DSS can't make a decision.
    - We don't want to get to the place where we have to say this funding has been used up and the CME program is not available until the next fiscal year.
- Counties think that the RIL plays into it, that if you are going to have to defend your decision re: sexual abuse you want to have documentation that a doctor found certain things in a medical exam.
- Counties would like to know if they could have the forensic interview first (and maybe only that) in certain circumstances when they are not sure that the medical exam will have benefits. (Ex: If child is already sexually active outside of the alleged abuse.)
- Belief that Law Enforcement will also be more comfortable going to the DA and requesting charges be filed if there has been a medical diagnosis. (Note from Laura that law enforcement can also pay for these evaluations.)
- She is NOT telling counties not to use the program, but wants to stress to use it appropriately.
- The Division will no longer allow backdating of signatures of consent forms. If the signature is not on the form it will not be approved for payment.
- Doctors were not timely in sending in invoices in the past – Division has now told providers that if the evaluation is not submitted within 2 months the programs will not pay for it, and the provider will have to absorb that cost.
- Need to open 212 on the 5027. Should be opened with the effective date that you get this signed and close it the day you get the evaluation. You do NOT need to put it on daysheets. (Appendix B of the SIS manual, page 15.)

Child & Family Evaluation (formerly called Child Mental Health Evaluations) – when do you do these?

- When parental behavior is causing emotional/mental health issues with the child – is very hard to prove emotional abuse.
- Do it if the CME recommends it.
- Not many counties here are doing them.
- The question was asked if there was an effort to recruit providers. There was – information was sent out last year seeking new providers. Focusing on the northeastern part of the state currently because there is a shortage of providers, but they are recruiting.
- For questions you can email Laura.Elmore@ncmail.net

Foster Care Visits/Foster Parent Recruitment and Retention

John gave an update on the 2 pieces. He had handouts detailing the history and next steps for these 2 items. Contact him for this information at: johnmcmahon@mindspring.com (These handouts – which include the tool - are attached at the end of these notes.)

Foster Care Visits

- The decision to work on this standardized tool came out of a federal mandate and also from the workgroup trying to better the recruitment and maintenance of foster parents.
- Monthly foster care contact record. Several counties participated in a workgroup to create a standardized tool to improve these visits. Hopes to: a) focus discussion and attention on the safety and well being of children in foster care and foster families, b) facilitate timely documentation and follow-up on identified needs, and c) support movement toward the intended outcomes for the children being visited.
- The Division started this work in 2006 working with the School of Social Work at UNC.
- Developed several prototypes of the tool, and January of 2007 the Division issued an invitation to participate in the pilot testing of the tool and 25 agencies responded and took part in this pilot. Agencies were asked to use a version of this tool one time a month during their required contact with children in care.
- Users saw a real benefit in using this tool, had some suggestions for modifications. These modifications were made and in January 2008 the tool was presented to Children's Services committee, who liked it but requested a few changes. Currently the plan is to resubmit to them in March, and if approved will be mandated for use sometime later during the year.
- Foster Parents and the Foster Parents Association was involved in the creation of this tool. The Foster Parents Association was initially concerned that the use of this tool would feel like an investigation, however they recognized the necessity of ensuring that this information was collected.
- This information will be put in the child's record, but may be shared with the licensing workers. Consulted with the Division Attorney who stated that this would not violate confidentiality.
- Bob Hensley shared that NC has a higher rate of abuse of children in Foster Care by Foster Parents than some other states, and hope that the use of this tool will help reduce these incidents.

- Once the tool has been put into place, this does not mean that we can't change it. After a period of time we can bring a group back together and get feedback on the use of the tool – aspects that are good, and areas that could be tweaked.
- The intent of the tool is to enhance the visit and prompt workers to address each of the issues, not to have workers read from it as a script. It takes about 40 minutes (the longer version did) but found that the more frequently a worker used it, the less time it took as they became more comfortable with it and incorporating these items became the norm with workers. Also, the worker may know some of the information prior to the visit.
- The Division has asked agencies to look at the requirements that they have and see if any of their forms, etc. can be given up because the information is already included in this tool so that workers are not having to duplicate information/reporting.
- Jordan Institute will develop an on-line training to assist workers in learning how to use the tool.

Update on Foster Parent Recruitment and Retention Campaign

- Prominent part of the Program Improvement Plan.
- Jordan Institute conducted a web survey of agencies – handout displays the geographic distribution of the agencies who responded and preliminary results of the survey.
    - 70% of agencies sometimes or often break up sibling groups in placements because there is not a foster home that can accept them all.
    - 5.6% of children are placed in group homes because there is a lack of family or therapeutic foster homes.
    - Agencies would like to see more foster homes for teens
    - Minority foster homes – nearly 75% of agencies had trouble recruiting minority foster parents but retention of them once recruited was not as much of an issue.
    - 11% of children were placed an hour away from their birth parents.
    - Regional approach – vast majority of respondents were open to this idea. Did not detail precisely what this might entail, but would be some sort of collaborative effort in order to maximize resources within a region.
- Jordan Institute is planning clinics around the state to talk to providers and others in your region. These clinics will focus on what people are trying now and what will be most helpful to counties in the future.
- Based on the feedback from the clinics, a toolkit will be developed and Jordan will also keep in contact with those who participate in the clinics to maintain information sharing.
- Also working with the Division to establish a baseline to track the foster parents that we have so that we can measure needs and progress.
- Even if your agency did not participate in the on-line survey you can participate in a clinic. There will be information coming out soon on how to sign up for these.

Developing a New Training

- Jordan Institute has been asked to develop a one day training on working with Drug Endangered children.
    - Will be changing the current Meth class to an on-line class and the Introduction to Substance Abuse from a 3 day to a 2 day course.

- Where do you struggle or stumble with working with these families. What would qualify as advanced practice or are you struggling with?
    - Helping parents understand how their behavior affects their children. How to get through to parents.
    - How to communicate the drug use as a family disease. How is the rest of the family enabling.
    - The general assessment itself – use does not constitute neglect, increase the training of the assessment for the social workers so that the social worker can accurately assess if the use is a problem. Then when they have done this, what does intervention look like based on the level of use.
- Do you think in the first two days of Introduction to Substance Abuse, some clarification about what kind of drug use constitutes *use* versus *abuse* versus *addiction* is necessary so that workers are not just going on their opinions which may be clouded by their personal values?
    - Yes.
    - Need to help social workers be aware of their own values and separate these from determining safety issues for a child. Possibly this should be its own training.
    - Also need to communicate with the community about what is neglect and that all use does not automatically does not mean that CPS will take custody of children.
    - Need to present addiction in other ways besides just the Disease Model – there are other models.
    - There is no place to send a parent who has already been sober for 30 days – they no longer qualify for many programs. Just because these people could get sober in a controlled environment in 30 days, they still need treatment and there are not a lot of places that they can go.
    - Provide some tools for agencies to use when parents cannot go to programs (because of work schedules, child care, availability). However, we need to make sure that we are not using some tools and calling it a substance abuse treatment program. More of an educational tool than a treatment tool.
- How do we leverage our power as CPS and getting these parents to become involved with treatment?
    - Once the case decision has been made, this is no different than any other family that is not addressing the safety issues in the case plan for in-home services.
    - Need to share the power with other family members and people that are important to the family – who will likely be much more effective in working with the family anyway, and will also be around to be part of a support network aftr DSS steps out of the family's life.
- Laura asked each county what were the primary drugs that they dealt with.
    - Almost all counties said crack or cocaine, and prescription drugs (esp methadone), as well as alcohol.
    - Some counties said marijuana, meth, and heroin.

<u>SOC Principle – Cultural Competence</u>

What does this mean to folks?

- Being aware of and sensitive to the cultural differences.

- Viewing the family as an individual family regardless of the categories that society puts them in. How do they live day to day and what does their culture mean to them, as opposed to social categories that they fit in.
- There are different cultures within each type of family. All Hispanic families are not the same. Families may be mixed within one broad category. Don't think you can treat all families that seem to be Hispanic the same. Have tried so hard to be conscious of trends for cultures that sometimes we think we are going something good by acknowledging these, but we need to determine the individual family's circumstances. (Ex: People have heard that you address the male first in a Hispanic household. However, that is not necessarily appropriate in all Hispanic households – some have been here for years and they do not necessarily want to be treated the same as a family that has been in this country for 6 months.)
- This principle supports the 6 Principles of Partnerships.
- Can't go by a script. Newer social workers may use more of a script to ensure they don't overlook anything, but more experienced workers can let the interactions flow more but still be conscious of cultural identities and get all the information they need to know while possibly leading the interactions in certain directions if necessary.
- Takes more time to do things this way but is worth the investment.
- Just because you are both speaking English does not mean that you are communicating as well as you could be because someone who does not speak English as their first language may not have the nuances to get across what they are trying to say.
- We usually think about culture for people that are different than us. But in some ways we need to be more sensitive to families that on the surface appear to be "just like us" because those families could be very different. (Ex: A Caucasian worker gets a Caucasian family and thinks that culturally they are the same, but one person's values and lifestyles could be totally different.)
- Need to ask questions of the family and not make assumptions about their culture – must do this every single time.
- Make sure that your values are not becoming the focus of your assessment. You are there to assess the safety of the children, not to judge a family based on your personal values.
- What do you do if there is something that is important to the family that the worker may be uncomfortable with? (Ex: A worker goes into the family's home and they always wanted to open with a prayer. This is the family's environment and it is not about the worker, should just go along.)

Are other partners in the community thinking about these issues?

- It is probably the least addressed question on the intake forms – reporters don't seem to know.
- In CFTs when the family is allowed to use their own communication styles (as long as they are not offensive to anyone) afterwards the community partners feel that DSS did not keep the meeting under control.
- Think this entire issue is about people being able to look at their own biases, and then step back and put them aside and realize "its not about you". Training only helps to a certain extent – you have to be able to do your own self evaluation. Someone at your agency has to be encouraging and supportive of you doing this.
- Supervision versus staffing. Can take a case and say to a worker "this family and some issues in this case seemed to strike a chord with you – we need to process

what those issues were and how that might have affected your decisions, positively or negatively" At that point there is a moment when it is no longer about the family but is about the social worker so that they can understand their own possible biases.

Contributory Factors

On the 5104 if you making a finding of substantiated or In Need of Services you are supposed to rank the Contributory Factors. We have heard that the choices are not very inclusive or helpful.

- There is nothing regarding sexual abuse – if the perp is committing sexual abuse what CF should we put?
- People would like some factors that did not require the medical diagnosis that the current contributory factors required because frequently the decision is made before the medical diagnosis can be made.
- Need to be able to address Mental Health issues without diagnosis because we can't hold the case open until MH can get an appointment and make a diagnosis.
- Also have a section for children who have emotional/behavioral issues that have not been medically diagnosed. Separate behavior (cutting) from emotional issues.
- Violence in the home that is not domestic violence.

Cross County Cases

You are supposed to be keeping a log of any cases that are cross county.

- Does anyone have a format for a log that they have developed and if so, could they email it to Holly?

March meetings:

Central: Rowan County March 25th – this is a change in date
Western: Asheville, AB Tech - March 27th
East: Lenoir Coop Ext, Kinston - March 18th

April meetings:

Central: Guilford Co DSS – April 22nd
Western: Asheville, AB Tech - April 14th - this is a new date, but the correct one – the previous date had to be changed
East: Edgecombe DSS – April 15th